Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-2361
Fax: (207) 287-7213; TTY: 1-800-606-0215

DENTAL CARE ACCESS CREDIT PROGRAM

Instructions: FAX the completed and signed form to the Maine Oral Health Program at (207) 287-7213. Send the form with an original signature in blue or black ink to: Director, Oral Health Program, ME CDC, 11 State House Station, 286 Water Street, 5th floor, Augusta, ME 04333-0011. Please type or print legibly.

Section I. Name: _____
(Your legal name as used for dental licensure, federal and state tax purposes)

Mailing address: _____

_____ _____
(City/town, State) *(Zip)*

Telephone: (___) _____

E-mail address: _____

Section II. Date initially licensed to practice dentistry in Maine by the Maine Board of Dental Examiners:

_____, 20____ License Number: _____

NOTE: Date of licensure must be January 1, 2009 or later in order to be eligible for this Program.

Section III. I attest that after January 1, 2009, I *(check one):*

___ **Joined** an existing dental practice in a dental health professional shortage area on _____.

___ **Purchased** an existing dental practice in a dental health professional shortage on _____.

___ **Established** a new dental practice in a dental health professional shortage on _____.

Name of practice: _____

Practice Address: _____
(Street address, City/town/ME, zip)

Section IV. By signing this form, I also attest that:
____ I agree that I will practice in a designated dental health professional shortage area for five years; and
____ I understand that the Dental Care Access Credit Program is available to me only for those years for which I am certified as eligible.

_____ _____
(Signature) *(Your legal name as above)* (Date)

TO RENEW: Complete all sections above and the following and return to the Oral Health Program:
By signing below, I attest that I:
____ am licensed to practice dentistry in Maine
____ have continued to practice dentistry in a designated dental health professional shortage area, located at:

_____
(Street address, City/town/ME, zip)

_____ _____
(Signature) *(Your legal name as above)* (Date)

Notice to Applicant: If certified, you will be required to report to the Oral Health Program on a quarterly basis to affirm that you continue to practice in a designated dental health professional shortage area.

Certification on following page

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

DENTAL CARE ACCESS CREDIT PROGRAM
Certification Page

For Oral Health Program use ONLY
Do not write or type below this line

Date/time received by Maine Oral Health Program: _____

Licensure date verified: ____ Yes ____No

Practice is located in a designated dental health professional shortage area: ____ Yes ____No

Application accepted and certified: ____ Yes

Certified by: _____
(Name and title, printed)

_____ _____
(Signature) *(Date)*

If **yes**, the above named applicant is eligible for the Dental Care Access Credit Program for 20_____.

To claim the credit, a copy of this certificate must be attached to the Maine individual income tax Form 1040ME along with the Dental Care Access Credit Worksheet for the appropriate tax year. A copy of the Worksheet is included with this Certification.

****

____ This application was received but was not certified for the Dental Care Access Credit Program for 20____.

____ Did not meet requirements ____ Was received after available positions were filled **

____ Other: _____

_____

_____
(Name and title, printed)

_____ _____
(Signature) *(Date)*

**** If you were not certified because available positions for calendar year 2009 were filled, and you would like to be considered for calendar year 2010, please check here ☐ and initial here _____ , and return this page <u>by fax</u> to (207) 287-7213, attn: Oral Health Program.**